Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PLAZA DAY SURGERY 909 9TH AVE FORTH WORTH TX 76104	MFDR Tracking #: M4-05-6206-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY MUTUAL FIRE INSURANCE Box #: 28	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Clearly the 'fair and reasonable' reimbursement for the medical services charges in this matter is best established by the agreed reimbursement a willing carrier has contractually agreed to pay for the medical services provided to Claimant… Requesting Party has contractual agreements with a network association for various carriers and employers (the 'Contract') other than Carrier and under the terms of the Contract Requesting Party is reimbursed at 57% of Requesting Party's usual and customary charges for medical services provided to claimants whose medical treatment is subject to the Texas Workers Compensation Act (the 'Act')… Requesting Party believes that the appropriate 'fair and reasonable' reimbursement rate that Carrier should pay to Requesting Party for its services to Claimant in this matter is this negotiated rate under the Contract or 57% (minus, of course, the prior payments by Carrier in this matter)."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $18,982.59

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The bill was paid per Texas Fee Schedule @ fair + reasonable per the Liberty Mutual ASC protocol, as described previously in a multitude of other disputes."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Codes	Disputed Services	Amount in Dispute	Amount Due
6/21/2004	X322, Z652, Z601, U849, X901, X070	Ambulatory Surgical Services	$8,782.86	$0.00
7/19/2004			$10,199.73	$0.00
		Totals:	$18,982.59	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on April 6, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 18, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - X322 – DOCUMENTATION TO SUBSTANTIATE THIS CHARGE WAS NOT SUBMITTED OR IS INSUFFICIENT TO ACCURATELY REVIEW THIS CHARGE.
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - Z601 – THE CHARGE EXCEEDS USUAL AND CUSTOMARY.
   - U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES.
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
   - X070 – LETTER TO FOLLOW.
2. This dispute relates to ambulatory services provided in an ambulatory surgical center with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, 22 TexReg 6264, which states that "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all pertinent records. The requestor did not submit a copy of the anesthesia record(s), nursing notes, recovery notes, diagnostic reports, discharge summary, or other pertinent medical records for consideration in this review. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "Clearly the 'fair and reasonable' reimbursement for the medical services charges in this matter is best established by the agreed reimbursement a willing carrier has contractually agreed to pay for the medical services provided to Claimant… Requesting Party has contractual agreements with a network association for various carriers and employers (the 'Contract') other than Carrier and under the terms of the Contract Requesting Party is reimbursed at 57% of Requesting Party's usual and customary charges for medical services provided to claimants whose medical treatment is subject to the Texas Workers Compensation Act (the 'Act')… Requesting Party believes that the appropriate 'fair and reasonable' reimbursement rate that Carrier should pay to Requesting Party for its services to Claimant in this matter is this negotiated rate under the Contract or 57% (minus, of course, the prior payments by Carrier in this matter)."
   - Texas Government Code § 2001.081 states that "The rules of evidence as applied in a nonjury civil case in a district court of this state shall apply to a contested case…" According to the Texas Rules of Evidence, Rule 1002 "To prove the content of a writing, recording, or photograph, the original writing, recording, or photograph is required except as otherwise provided in these rules or by law." Review of the requestor's documentation finds that the requestor did not submit a copy of the alleged contract for consideration, nor did the requestor demonstrate that any exception to this requirement applies to the documentation in this dispute. The contractual rate is not supported.
   - The requestor submitted two redacted EOBs with an affidavit stating "I have attached hereto a redacted copy of an EOB issued to Plaza evidencing payments for services provided to a workers' compensation claimant evidencing the 57% reimbursement rate paid for Plaza's medical services consistent with the terms of the contractual agreements." However, the requestor did not submit redacted medical bills or other documentation to establish that the services

paid on the redacted EOBs were the same or similar to the services in dispute.

- Review of the redacted EOBs finds no explanation on the EOB of the contractual rate or the methodology used to determine the payment amount for each sample EOB.
- The requestor did not provide documentation to support whether such payment was typical for the disputed services.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**8/26/2010**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luevano	**8/26/2010**
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.